UNITED STATES OF AMERICA
BEFORE THE NATIONAL LABOR RELATIONS BOARD

CROZER-CHESTER MEDICAL CENTER, Employer, and	
	Case 04-RC-164030
PENNSYLVANIA ASSOCIATION OF STAFF NURSES AND ALLIED PROFESSIONALS Petitioner.	

REQUEST FOR REVIEW OF THE ACTING REGIONAL DIRECTOR'S DECISION AND DIRECTION OF ELECTION
BY THE EMPLOYER, CROZER-CHESTER MEDICAL CENTER

Submitted By:

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INTRODUCTION

Pursuant to Sections 102.67(d) of the National Labor Relations Board's Rules and Regulations, Crozer-Chester Medical Center ("CCMC") requests review of the Acting Regional Director of Region 4's Decision and Direction of Election (the "Decision"). The Decision stands as a dramatic departure from Board precedent concerning the scope and impact of the Board's Health Care Rule. It also ignores and mischaracterizes key facts made clear in the record, leading to erroneous conclusions concerning the interests shared by the two distinct sets of employees Petitioner seeks to add to its existing unit and whether they, together, constitute a distinct identifiable group. Finally, the Decision was affected by procedural irregularities, including indications that the merits of the Petition were prejudged, and thus resulted in prejudicial error.

Specifically, the Decision relies upon the Health Care Rule (the "Rule") in order to ignore the Board's traditional community-of-interest analysis and approve the Petitioner's attempt to add a group of clinical assistants to its existing unit of paramedics and Emergency Medical Technicians ("EMTs") and those on-call paramedics and EMTs whose inclusion in the unit is not contested. [ARD Dec. at 5-6].[1] But, this reading of the Rule is flawed. As an initial matter, no evidence in the record supports the conclusion that the current members of Petitioner work at an acute care hospital, a prerequisite for the Rule to be a relevant consideration. Instead, Petitioner's unit is comprised of paramedics and EMTs who spend a vast majority of their time outside the hospital, in the stations to which they report, and in the homes and offices of patients

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[1] Herein, citations to the Acting Regional Director's Decision will be "ARD Dec." Citations to the hearing transcript will be "Tr." followed by page numbers. Exhibits will be cited as designated at the hearing.

where they respond to emergencies. Therefore, the Rule is wholly inapplicable to the case at hand.

Further, by its own terms, the Rule does not apply to petitions for self-determination elections relating to pre-existing non-conforming units. Such an election is precisely what the Petition here seeks: A unit of paramedics and EMTs has existed since the 1970s, as have other, separate units that include technical employees, some in combination with non-technical employees. The Petition wishes to add other paramedics and EMTs, as well as the disputed clinical assistants. Because a self-determination election is appropriate in such a circumstance, the Health Care Rule does not apply.

Therefore, the presumption on which the Decision relies, which it explicitly bases on the Health Care Rule alone, is wholly inapplicable. Instead, the Decision should have performed a traditional community-of-interest analysis, as required by clear Board precedent. It failed to do so, resulting in prejudicial error.

In addition, even if the Health Care Rule were applicable, it provides for an exception in extraordinary circumstances. The Acting Regional Director failed to meaningfully consider whether the facts here satisfy this standard. Careful review of the record, however, reveals that the circumstances presented here were not considered by the Board when it established the Rule and, thus, fit within the Rule's definition of "extraordinary." For these reasons, the Acting Regional Director applied the Health Care Rule inappropriately. Therefore, CCMC requests review so that the Board may correct these errors and direct the Acting Regional Director to analyze whether the Petition's proposed grouping of workers is appropriate under a traditional community-of-interest analysis.

The error caused by the Decision's flawed application of the Health Care Rule is compounded by its misinterpretation of the record. Indeed, it ignores important facts concerning differences between paramedic/EMTs and clinical assistants, as well as the limited ways in which the two groups interact. In one glaring example of its slanted recitation of facts, it depends upon the testimony of one clinical assistant that the work she once did as a paramedic is "basically the same" as that she does now. [ARD Dec. at 6]. The Decision fails to mention that that individual's experience as a paramedic was for a different employer and took place six years ago [Tr. at 116], and that her testimony was contradicted by every other witness who testified at the pre-election hearing. This and other misstatements of the record lead the Decision to conclude that paramedic/EMTs and clinical assistants share a community of interest and constitute a distinct identifiable group appropriate for bargaining. Both of these conclusions are contradicted by a more accurate portrayal of the facts. Therefore, CCMC requests review so that the Board may undertake a more careful review of the record, which will demonstrate that, under Board precedent, grafting the clinical assistants onto an existing unit of paramedic/EMTs is inappropriate.

Finally, the circumstances in which the Decision was announced suggest that it was the result of prejudgment. A day before the Decision issued, an entry on the case's online docket indicated that a decision on the merits of the Petition had been made. An accompanying order stated that both sought-after groups – the part-time paramedic/EMTs and the clinical assistants – would be included in a self-determination election. In other words, it granted Petitioner everything it sought. Later that day, the Regional Office instructed the parties to ignore the docket entry because the case was still under review. Yet, the fact that the docket entry had been prepared in advance to match the Petitioner's desired result and exactly tracking

the ultimate outcome raises the likelihood that the Regional Office prejudged the issue disputed at the hearing, resulting in prejudice to CCMC.

Therefore, CCMC requests review of the Decision on the following grounds: (1) a substantial question of law or policy is raised because of the departure from reported Board precedent in that the Acting Regional Director misapplied the Health Care Rule; (2) the Acting Regional Director's decision on substantial factual issues – namely, the extent of the community of interests shared by clinical assistants and paramedic/EMTs and that the two groups combined constitute a distinct identifiable group suitable for collective bargaining – is clearly erroneous on the record and such error has prejudicially affected CCMC's rights; and (3) the conduct of the hearing and the manner in which the Regional Office announced the Decision were procedurally irregular, demonstrating that the issues under consideration were prejudged and resulting in prejudicial error.

Accordingly, CCMC respectfully requests that the Board grant review and reverse the Acting Regional Director's decision.

I. FACTUAL BACKGROUND

A. General Background

CCMC is a hospital and member of the Crozer-Keystone Health System (the "Health System") located in Upland, Pennsylvania. [Tr. at 108]. In addition to CCMC, other hospitals in the Health System are Delaware County Memorial Hospital, Taylor Hospital, Springfield Hospital, and Community Hospital. [*Id.* at 108-09]. CCMC sits on a campus of several city blocks and is comprised of approximately 25 buildings [*Id.* at 30, 109]. Organizationally, it is made up of several divisions, some of which span the entire Health System and some that specific to a member hospital. [CKHS Organizational Chart, Joint Exhibit 7].

In 1996, the Board certified a group of paramedics employed by CCMC as a bargaining unit under the Act. [Certification of Representation, Case No. 04-RC-18990, Joint Exhibit 5]. The unit was certified to include "[a]ll full time and regular part time paramedics and relief lead paramedics employed by the Employer based out of its facility currently located at 1 Medical Center Blvd., Upland, PA." [*Id.*]. At the time, the unit was represented by the Laborers' International Union of North America, AFL-CIO, Local 1319 ("LIU"). [*Id.*]. In 2002, Petitioner, the Pennsylvania Association of Staff Nurses and Allied Professionals ("PASNAP") sought and achieved representation of the same unit. [Certification of Representation, Case No. 04-RC-20439, Joint Exhibit 6; Tr. 13-14]. Since that time, CCMC and PASNAP have been parties to several collective bargaining agreements, the last of which expired on December 21, 2014. [December 22, 2011 - December 21, 2014 Collective Bargaining Agreement between Crozer-Chester Medical Center and PASNAP (the "PASNAP CBA"), Joint Exhibit 1].[2] In this agreement, CCMC recognized PASNAP as the representative of "all full-time and regular part-time Emergency Medical Technicians, Paramedics and Paramedic Lieutenants employed to provide pre-hospital and inter-hospital EMS transport functions, as certified by the National Labor Relations Board." [*Id.* at Art. 3, § 1(a); ARD Dec. at 2]. There are approximately 51 paramedics and EMTs included in the unit. [ARD Dec. at 2; Tr. at 29]. PASNAP also represents CCMC's nurses. [June 9, 2011 – June 8, 2014 Collective Bargaining Agreement between Crozer-Chester Medical Center and PASNAP, Joint Exhibit 2].

Several other unions represent other groups of CCMC employees. Specifically, the National Union of Hospital and Health Care Employees, District 1199C ("1199C")

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2 CCMC and PASNAP have recently agreed to a successor to the PASNAP CBA which does not modify its recognition clause. [June 23, 2015 Memorandum of Agreement, Joint Exhibit 1-A].

represents "all full-time and regular part-time technical Employees" employed by CCMC. [ARD Dec. at 2; September 28, 2012 Collective Bargaining Agreement between Crozer-Chester Medical Center and 1199C, Joint Exhibit 4, at Art. 1, § 1.A]. LIU represents CCMC employees in several classifications, including Licensed Practical Nurse, Patient Care Technician, and Surgical Technician. [ARD Dec. at 2; July 1, 2011– September 30, 2016 Collective Bargaining Agreement between Crozer-Chester Medical Center and LIU, Joint Exhibit 3, at Art. 1]. There is also a unit comprised of CCMC's pharmacists. [June 9, 2011 – June 8, 2014 Collective Bargaining Agreement between Crozer-Chester Medical Center and PASNAP, Joint Exhibit 2; Tr. at 14].

B. Classifications PASNAP Seeks to Add to Its Existing Unit

The Petition seeks to add to the current unit of paramedics and EMTs "all [PRN] paramedics employed [by] Crozer-Chester Medical Center, and all regular full-time, ... regular part-time, and [PRN] paramedics working as clinical assistants, working at Crozer-Chester Medical Center." [Tr. at 7, 10, 201].[3] CCMC did not oppose the Petition to the extent it sought to allow PRN paramedic/EMTs the opportunity to join the existing PASNAP unit by means of a self-determination election. [*Id.* at 10]. However, it does oppose the potential inclusion of clinical assistants within this unit because they do not share a community of interest with CCMC's paramedic/EMTs and because the two groups combined do not comprise a distinct, identifiable group suitable for collective bargaining. As made clear on the record and explained below, the two groups of employees share almost no terms and conditions of employment in common, nor are they, together, a distinct and identifiable group.

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[3] "PRN" is an abbreviation for the Latin phrase "*pro re nata*," a term the parties used at times interchangeably with "per diem." In short, employees known as "PRNs" are on-call employees not included within the category of "regular part-time." [Tr. at 28].

1. Paramedics and EMTs

a. Structure of EMS Department

Robert Reeder is the Chief of CCMC's Emergency Medical Services ("EMS"). [Tr. at 26-27]. In this position, he is responsible for the day-to-day operation of CCMC's EMS, including the work of its paramedics and EMTs. [*Id.* at 27]. He reports to Jerry Madden, Director of EMS for the Health System. [*Id.* at 33, 51]. Mr. Madden reports to Robert Haffey, the President of Delaware County Memorial Hospital and Taylor Hospital. [*Id.*; CKHS EMS South (CCMC) 2015 Organizational Chart, Employer Exhibit 1]. Mr. Haffey reports to Patrick Gavin, the Executive Vice President and Chief Operating Officer of the Health System and President of CCMC. [CKHS Organizational Chart, Joint Exhibit 7].

As Chief Reeder explained, there are only four employee classifications in the EMS: EMTs, paramedics, chief, and assistant chief. [Tr. at 27-28]. In total, EMS has approximately 81 employees, including 30 PRN EMTs and paramedics. [*Id.* at 28]. Therefore, 51 are represented by PASNAP and have their terms and conditions of employment governed by the PASNAP CBA. [*Id.* at 29]. As first responders, paramedics and EMTs wear a uniform similar to that worn by other fire and emergency workers. [*Id.* at 85, 91-92].

EMTs and paramedics work out of eight stations located throughout Delaware County, Pennsylvania. [*Id.* at 29]. One of these stations, which also functions as EMS headquarters, is located on the grounds of CCMC. It is known among the employees of EMS as "Station 100." [*Id.*]. Station 100 is where Chief Reeder and his assistant chiefs work. [*Id.* at 29, 52]. The other locations out of which EMTs and paramedics are dispatched are as follows:

- Community Hospital, located in Chester, Pennsylvania
- Aston Township Fire Station
- Bethel Township Township Building

- Parkside Fire Company
- Tinicum Township Fire Department
- Marcus Hook Fire Department
- Taylor Hospital in Ridley Park, Pennsylvania

[*Id.* at 29-30]. Of these, only Station 100, however, is located on the grounds of CCMC. The others are up to eight miles away. [*Id.* at 35]. Even Station 100 is located in a different building than the hospital itself (which is where the Emergency Room ("ER") is located), across CCMC's sprawling campus. [*Id.* at 30]. Chief Reeder estimated that Station 100 is two and one-half blocks away from the hospital. [*Id.*]. There is a small office within the ER set aside for EMS personnel to use for writing charts and gathering supplies before they go on their next call. [*Id.* at 55]. Nevertheless, most paramedic/EMTs prepare their required documentation remotely. [*Id.* at 60].

Chief Reeder estimated that eight to nine EMTs and paramedics work out of Station 100 at any given time, on a 24-hour rotating schedule. [*Id.* at 31]. Two paramedics or EMTs are stationed at Community Hospital, Aston Township, Marcus Hook, and Bethel Township at a time, 24 hours per day. [*Id.* at 31-32]. One paramedic or EMT is assigned to the remaining stations, also at all times. [*Id.* at 32-33]. Paramedics and EMTs are assigned to these stations on a rotating basis via a published schedule. [*Id.* at 36]. They report to their assigned stations at the start of each shift in order to check their equipment and respond to emergency calls as they are received. [*Id.*]. They work shifts of eight, 12, or 16 hours on a rotating basis. [Tr. at 159, 167]. Their schedules are made by a committee of PASNAP members that is approved by an EMS assistant chief. [*Id.* at 170-71].

b. Function and Responsibilities of Paramedic/EMTs

Chief Reeder described paramedics and EMTs' duties as follows:

> Their job is . . . to get to the [emergency] call safely, see their patient or take care of whatever incident they're at. If patients need medical care, they're to deliver that care and then transport them to the appropriate hospital, if needed.

[*Id.* at 36]. Christopher Yates, a paramedic and the president of PASNAP, also testified as to paramedics and EMTs' duties:

> Primary concern of the job is when we are dispatched to a call that we answer the call. We go and we care for the sick or injured that we find at the call, make a determination for the most appropriate facility that they go to while we are treating them up to an advanced life support level, and then deliver them to the appropriate hospital.

[Tr. at 160]. These duties are also referenced in the job descriptions CCMC maintains associated with the paramedic and EMT positions. [*See* Job Description/Performance Appraisal: Paramedic, Employer Exhibit 2 ("Paramedic Job Description"); Job Description/Performance Appraisal: Emergency Medical Technician, Employer Exhibit 4 ("EMT Job Description")]. As explained in their job description, paramedics are responsible for the following:

- Providing "quality pre-hospital emergency basic and advanced life support pre-hospital care to victims of sudden illness and/or injury;"
- Providing advanced life support ("ALS")/basic life support ("BLS") "individual unit leadership, in order to assure safe and efficient EMS operations and a quality team approach to patient care;"
- Providing "one on one clinical training for pre-hospital providers of lesser certifications and/or experience level;"
- Providing "community volunteer fire company ambulance service assistance, and assure of the timely delivery of quality pre-hospital advanced and basic life support emergency patient care;" and
- Providing "first aid, CPR, and EMS education to the lay public, industry, and other EMS agencies."

[Employer Ex. 2]. Consistent with these duties, paramedics and EMTs perform any number of patient-care activities, including using an electrocardiogram ("EKG") machine and interpreting its results, drawing patients' blood, preparing and inserting intravenous ("IV") lines, and dispensing medication. [Tr. at 163-64, 166]. When they provide this care, they apply protocols established by the Commonwealth of Pennsylvania. [*Id.* at 164, 166]. Occasionally, they may need to discuss a situation with a doctor, in which case they consult with one in the ER. [*Id.* at 64-67, 164, 166]. EMTs fill a nearly identical role, except that EMTs are not certified to perform body invasive procedures. [*Id.* at 37]. Paramedics are also called upon to train their peers and other CCMC employees – including clinical assistants, nurses, and doctors – as well as non-CCMC or Health System employees who provide patient care. [*Id.* at 56-58].

Both paramedics and EMTs must have several specific forms of certification and training, including pre-hospital life-support ("PHTLS") or basic trauma life-support training ("BTLS"), emergency vehicle driver training, advanced cardiac life-support ("ACLS") provider certification, and basic firefighting training. [*Id.* at 41-43; Employer Exs. 2, 4]. As Chief Reeder explained, many of these training and certification requirements are imposed by the Commonwealth of Pennsylvania, which carefully regulates the work of paramedics and EMTs. *See* 28 Pa. Code §§ 1001 *et seq.* (2015). [*See also* Tr. 37-38]. The Commonwealth also requires that, in order to deliver patient care as a paramedic, one must be certified by an authorized physician (known as "medical command") as having the appropriate skills and education to deliver basic life support and, for paramedics, advanced life support, consistent with the Commonwealth's established protocols. [*Id.* at 37; Medical Command Authorization Form, Employer Exhibit 3]. This requirement is incorporated into CCMC's Paramedic Job Description. [Tr. at 38; Employer Ex. 2].

The Commonwealth also places strict limitations on what sort of work paramedics can perform in hospital emergency rooms. [Tr. at 47-48]. Specifically, in 2001, the Commonwealth's Department of Health issued a memorandum to all EMS directors explaining that, except in the direst situations, paramedics are not permitted to provide medical care in an emergency room. [*Id.* at 48-49; Pa. Department of Health Memorandum (July, 30, 2001) ("DOH Memo"), Employer Exhibit 5]. As stated in the DOH Memo, Pennsylvania "does not authorize paramedics to function as integral staff of the hospital emergency services area while on duty as a paramedic, nor does it permit the paramedic to serve in that capacity when not on duty unless the paramedic otherwise qualifies to do so, such as if the paramedic is also licensed as a nurse." [*Id.* at 1]. The reason for this regulation is that paramedics provide direct patient care consistent with their medical command certification, a certification which does not apply within the hospital walls. [Tr. at 49-50]. There, doctors and nurses alone provide patient care. [*Id.*].

When paramedics and EMTs transport a patient – after they provide that patient with whatever care they deem necessary – to a hospital, they are typically met by the nurse in charge of the ER, known as the "charge nurse." [Tr. at 47-48]. They then transport the patient to an assigned room and transition care to a nurse or doctor. [Tr. at 48]. The CCMC paramedics and EMTs can transport patients to any hospital, though the vast majority is transported to CCMC itself. [*Id.* at 63, 160]. When they arrive at CCMC, paramedic/EMTs typically bring the patient to a "back" entrance to the ER, distinct from that used by walk-in patients. [*Id.* at 161]. At times, after they bring a patient to the back, paramedics and EMTs may bring the patient to the "front" – i.e., where walk-in patients enter – if, for example, no room is available in the ER's patient care space. The decision to take the patient to the front of the ER is made by the paramedic/EMT and the charge nurse on duty. [*Id.* at 169]. Mr. Yates testified that, when he is

working out of one of CCMC's two Chester-based stations, he may also bring patients to out-patient clinics. [*Id.* at 162-63]. These destinations, combined with the times he brings a patient to the front of CCMC's ER, make up 50% to 70% of the patient-transports he makes when working out of a Chester-based station. However, when he is working out of any of the other five stations to which he is regularly assigned, he brings patients to the ER's front "far less often," and as little as 25% of the time. [*Id.* at 163].[4]

When paramedics and EMTs transition a patient to the care of ER staff, they "give report" – i.e, update the staff on the status of the patient, his or her complaint, and what care has been provided thus far. [*Id.* at 161]. If a patient is assigned to the ER's patient care area, report must be given to a doctor or nurse. [*Id.* at 170]. When a patient is assigned to the ER's front area, report may be given to a clinical assistant. [*Id.* at 161-62]. Regardless of the destination of the patient, paramedics and EMTs' stay in the hospital is short. They anticipate getting a call to respond to an emergency every three and a half minutes. [*Id.* at 169].[5] Therefore, they promptly turn over care to ER staff and depart. [*Id.*].

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4 While much of the discussion on the record concerned the time paramedics and EMTs spend in Crozer's ER and at their assigned stations, it is important to note that most of their work takes place in neither location: Instead, the nature of their jobs requires them to provide pre-hospital care, meeting patients in their homes or elsewhere and providing those patients with care and transport. [Tr. at 165]. As Mr. Yates testified, paramedics and EMTs spend no more than 10% of their time in any ER (CCMC's or another hospital's combined) during a typical shift. [*Id.* at 166]. If a patient is brought out front, the paramedic/EMT is typically in the front area for less than five minutes before he or she departs on another call. [*Id.* at 169].

5 While the transcript portrays Mr. Yates as saying "we're likely going to get another call in the next three and a half seconds," [Tr. at 169], CCMC believes this to be a typo.

c. Other Terms and Conditions of Employment

Beyond their duties and supervisory structure, the terms and conditions of the paramedics and EMTs' employment are set by the terms of the PASNAP CBA. [*See* Joint Exs. 1, 1-A; Tr. at 96]. For example, their wages are set by a negotiated wage scale. [Tr. at 96-97; Joint Ex. 1-A at 2-3]. So too are premiums they must be paid for working overtime and on specific shifts. [Tr. at 110-11; Joint Ex. 1 at 18-19]. While they have some of the same benefits options as other Health System employees, they also are permitted to participate in a tax-sheltered annuity and a Section 403(b) plan not available to others. [Tr. at 99; Joint Ex. 1-A at 4-5]. Holidays and paid time off are also set by the terms of the PASNAP CBA and distinct from that provided under CCMC's general policies. [Tr. at 104-05; Joint Ex. 1 at 18-24]. PRN paramedics and EMTs are not eligible to participate in any benefit plans and have a separate compensation rate, based on their assigned shift. [Tr. at 100].

2. Clinical Assistants

a. Structure of Emergency Department

Clinical assistants are technicians in CCMC's ER. They are a part of CCMC's Division of Nursing and Patient Services. [Tr. at 70, 84; Joint Ex. 7]. As such, they report to the Clinical Director of the CCMC Emergency Department, Tony Ciccarone, who is similar to a "head nurse" for the hospital. [Tr. at 71, 84, 87]. Ms. Ciccarone reports to Eileen Young, Vice President for Patient Services and Chief Nursing Officer for the Health System. [Tr. at 70; Joint Ex. 7]. Ms. Young reports to Patrick Gavin. [*Id.*]. There are seven full-time clinical assistants and six PRN clinical assistants at CCMC. [Tr. at 84].

b. Function and Responsibilities of Clinical Assistants

As Ms. Young explained, clinical assistants are responsible for helping with patient in-take at the CCMC ER, including taking vital signs, taking and analyzing EKGs, and

preparing IVs to be inserted by nurses.[6] [Tr. at 72]. They also aid in transporting some patients to other areas in the hospital – specifically, those patients whose condition requires a low level of electronic monitoring, but not critical care. [*Id.* at 72-73, 83]. In this regard, their work is similar to that performed by other classifications of CCMC employees, such as patient care technicians and licensed practical nurses ("LPN"). [*Id.* at 75]. Other than when they transport a patient elsewhere within CCMC, clinical assistants' work is confined to the CCMC ER. [*Id.* at 72-73, 165].

Clinical assistants are supervised by a nurse or LPN. [Tr. at 74; Clinical Assistant Job Description, Employer Exhibit 6]. They are assigned to either the front or back area of the ER. When out front, they work with non-medical patient access personnel in greeting walk-in patients and assessing their immediate needs. [Tr. at 76, 83]. When working in back, clinical assistants take direction from medical staff, but may not themselves perform ACLS, administer medicine, insert IVs, or perform other patient-care activities outside the scope of their duties. [*Id.* at 77-78]. CCMC requires that clinical assistants be certified as either paramedics or EMTs, but does so only to ensure that they have at least the level of skill necessary to perform their limited patient care and monitoring responsibilities. [Employer Ex. 6; Tr. at 74-75]. Consistent with the Pennsylvania regulations discussed above, CCMC does not allow clinical assistants to

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[6] Throughout the hearing held in this matter, the term "triage" was used frequently. Ms. Young defined triage as "a process of evaluating patients as they arrive, and making judgments about the severity of their illness, and making judgments about how quickly they need to receive care." [*Id.* at 79]. As Ms. Young explained, and as current clinical assistant Beverlie Potter agreed, clinical assistants do not provide a "triage-level" of care. [*Id.* at 80, 150-51]. That form of care is delivered exclusively by doctors and nurses. [*Id.* at 80]. Nevertheless, the front of the ER was referenced several times on the record as the "triage area" or simply "triage." [*See, e.g., id.* at 117]. That terminology, however, should not be read to contradict evidence concerning the level of care provided by various CCMC personnel, particularly since no evidence suggests clinical assistants provide care beyond the scope of their job descriptions.

actually function as paramedics while doing their jobs. [Tr. at 75]. Thus, while three current CCMC paramedics have worked shifts as clinical assistants in the past year, no clinical assistants have worked as EMTs or paramedics for CCMC during that time. [*Id.* at 62]. Also of note, while CCMC paramedics' duties include training other individuals involved in patient care, including clinical assistants and including non-CCMC employees [*Id.* at 56-58, 133; Employer Ex. 2], clinical assistants do not provide such training. [Tr. at 134].

Clinical assistants work eight and 12-hour shifts on schedules that are approved by their Clinical Director so that at least one clinical assistant is on duty at all times. [*Id.* at 87, 90, 100, 107]. While on duty, they wear hospital scrubs. [*Id.* at 85]. They typically work in two-person teams on each shift, rotating from the back of the ER to the front (or vice versa) approximately half-way through each shift. [*Id.* at 121]. When in back, they will take direction from a nurse or shift manager, or decide on their own to assist with patients that require attention. [Tr. at 124]. When an ambulance arrives, clinical assistants may assist in meeting the patient. [*Id.* at 125]. According to Ms. Potter, however, "nine out of 10 times," the patient and escorting paramedics or EMTs are met by a nurse. [*Id.* at 126-27]. Ms. Potter also testified that she is "constantly taking people upstairs" – i.e., to other parts of the hospital, an activity that does not bring her into contact with paramedics or EMTs. [*Id.* at 131, 149, 151-52]. She thus estimated that well less than half her time was spent in contact with paramedics or EMTS and that, when she did interact with them, it was for fewer than 15 minutes at a time. [*Id.* at 131-32].

At times, patients are brought out front by paramedics because the ER is full. [*Id.* at 157]. Ms. Potter testified, when working out front, in a month's time, approximately 30% to 40% of her patients may be escorted there by paramedics. [*Id.* at 155-56]. As Ms. Potter acknowledged, whether they deliver a patient to the back of the ER or to the front, paramedics

and EMTs leave quickly. [*Id.* at 142-43]. As she also acknowledged, those paramedics and EMTs who deliver patients to CCMC's ER may come from any number of hospitals or other locations, including some outside the Health System. [*Id.* at 140].

c. Other Terms and Conditions of Employment

The other terms and conditions of clinical assistants' employment are similar to those of other, full-time non-unionized CCMC personnel. They are paid a wage consistent with CCMC's general salary scale, which does not provide for step-increases similar to those mandated for paramedics and EMTs. [*Id.* at 96]. Their benefits and time-off are consistent with CCMC's general policies, which differ from those described in the PASNAP contract. [*Id.* at 99, 103-04; CKHS Vacation Time Policy, Employer Exhibit 8].

In sum, nearly all of the terms and conditions of employment of the paramedic/EMTs and the clinical assistants diverge, including every one of the factors the Board looks to determine whether separate groups of employees may be combined for purposes of collective bargaining. Therefore, they neither share a community of interest nor are they a distinct and identifiable group. The Decision ignores these facts and misapplies the appropriate Board precedent concerning application of the Health Care Rule. The result is direction of an election in an inappropriate unit, grafted together in violation of the Act. Therefore, the Board should exercise its discretion to review the Decision and grant appropriate relief.

II. THE ACTING REGIONAL DIRECTOR'S DECISION AND DIRECTION OF ELECTION

The Decision concludes that (1) under the Health Care Rule, clinical assistants and paramedic/EMTs, as technical employees, share a presumptive community of interest and (2) that the two groups of employees together constitute a distinct identifiable group appropriate for bargaining. [ARD Dec. at 5-8]. Therefore, it orders a self-determination election be held in

which both groups of employees named in the Petition – the PRN paramedic/EMTs that have not historically been members of PASNAP and the full-time, part-time, and PRN clinical assistants – will vote to determine whether they will join PASNAP's paramedic/EMT-only unit. [*Id.* at 1, 9].

It reaches this conclusion based on the notion that "[t]he Board's Health Care Rule . . . establishes eight bargaining units which are considered presumptively appropriate in acute care hospitals, and employees in each of those units are presumed to share a community of interest." [*Id.* at 4-55 (citing *St. Vincent Charity Med. Ctr.*, 357 NLRB No. 79, slip op. at 2 (2011)]. It states that, "where a union seeks to add employees to an existing non-conforming unit in an acute care hospital," this presumption applies and "normal community-of-interest standards are not determinative in deciding whether employees in the voting group will be permitted to vote on inclusion." [*Id.* at 5].

It then purports to analyze the facts, but stating that it will only consider whether those facts are sufficient to overcome the "'heavy burden'" it determined applies under the Health Care Rule. [*Id.* at 5]. According to the Decision, a number of facts point to exclusion of the clinical assistants from PASNAP's EMT/paramedic unit under traditional community-of-interest analysis, such as their separate supervision, distinct work areas, limited interchange, and distinct duties and training. [*Id.* at 5-6]. On the other hand, it states that the two groups have "regular contact," "similar skill levels," and similar functions. [*Id.* at 6]. Therefore, it finds, the facts do not suggest that there is a sufficient disparity of interest between the groups of employees to overcome the presumption imposed by the Health Care Rule. [*Id.* at 6-7]. Further, based on its conclusion that the employees "perform broadly similar functions," it finds that they constitute a distinct and identifiable group suitable for bargaining. [*Id.* at 8].

For the reasons explained below, these conclusions demonstrate departure from Board precedent, a flawed reading of the record, and procedural irregularities sufficient to warrant Board review.

III. WHEN THE BOARD MAY GRANT A REQUEST FOR REVIEW

The Board may grant discretionary review of a Regional Director's decision upon one or more of the following grounds:

> (1) That a substantial question of law or policy is raised because of:
>
> (i) The absence of, or
>
> (ii) A departure from, officially reported Board precedent.
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> (2) That the regional director's decision on a substantial factual issue is clearly erroneous on the record and such error prejudicially affects the rights of a party.
>
> (3) That the conduct of any hearing or any ruling made in connection with the proceeding has resulted in prejudicial error.
>
> (4) That there are compelling reasons for reconsideration of an important Board rule or policy.

29 C.F.R § 102.67(d) (2015).

Here, the Board should grant CCMC's request for review because the Decision departs from controlling Board precedent, the Decision contains errors on substantial factual issues that have prejudiced CCMC's rights, and the Decision was announced in a procedurally irregular fashion, demonstrating that the issues before the Regional Office were pre-judged.

IV. ARGUMENT

A. The Acting Regional Director Erred Through Misapplication of the Health Care Rule.

In the Health Care Rule, the Board establishes eight categories of employees that, in the circumstances the Rule describes, are deemed appropriate units for purposes of collective

bargaining. 29 C.F.R. § 103.30 (2015). Those categories are registered nurses, physicians, other professional employees, technical employees, skilled maintenance employees, business office clerical employees, guards, and other nonprofessional employees. *Id.* However, the Rule is not universally applicable. Instead, by its own terms, it has three specific limitations: First, it only applies to bargaining units in acute care hospitals. *Id.* at § 103.30(a), (g) ("The Board will determine appropriate units in other health care facilities as defined in section 2(14) of [the Act]."). Second, the Rule does not apply "in circumstances in which there are existing non-conforming units." 29 C.F.R. § 103.30. Third, it does not apply in "extraordinary circumstances" – i.e., whenever a party can demonstrate "that its arguments are substantially different from those which have been carefully considered at the rulemaking proceeding," for example when "unusual or unforeseen deviations from the range of circumstances revealed at the hearings and known to the Board from more than 13 years of adjudicating cases in this field, [suggest] that it would be unjust or an abuse of discretion for the Board to apply the rules to the facility involved." Collective Bargaining in the Health Care Industry, 53 Fed. Reg. 33,900, 33,932 (Sept. 1, 1988) (quotation omitted).

A full and fair reading of the record demonstrates that each limitation applies here, rendering the Health Care Rule irrelevant. Yet, the Decision relies upon the Rule exclusively as the basis for its determination that CCMC's paramedic/EMTs and clinical assistants should be grouped together for purposes of bargaining, applying a presumption derived from the Rule that is inapplicable in this case. Therefore, the Board should review the Decision in order to require application of traditional community-of-interest analysis.

1. CCMC's Paramedic/EMTs Do Not Work at an Acute Care Facility.

By its very terms, the Health Care Rule applies only in acute care hospitals. 29 C.F.R. § 103.30(a). It defines such facilities as "either a short term care hospital in which the

average length of patient stay is less than thirty days, or a short term hospital in which over 50% of all patients are limited to units where the average length of patient stay is less than thirty days." *Id.* at § 103.30(f)(2). The Rule does not apply in other healthcare settings. *See Specialty Healthcare & Rehab Ctr. of Mobile*, 357 NLRB No. 83 (2011). Instead, the Board has specifically stated that it would weigh the "traditional community-of-interest considerations in determining if a proposed unit is an appropriate unit in nonacute health care facilities." *Id.*, slip op. at 12. In such circumstances, the Board examines the following factors:

> [W]hether the employees are organized into a separate department; have distinct skills and training; have distinct job functions and perform distinct work, including inquiry into the amount and type of job overlap between classifications; are functionally integrated with the Employer's other employees; have frequent contact with other employees; interchange with other employees; have distinct terms and conditions of employment; and are separately supervised.

Id. at 14 (quoting *United Operations, Inc.*, 338 NLRB 123, 123 (2002)). Thus, outside of an acute care hospital, the Board engages in a fact-specific inquiry when evaluating the proposed unit's composition to determine whether it is an appropriate unit.

Here, it is undisputed that the paramedics and EMTs Petitioner represents, and those PRN paramedics and EMTs it seeks to add to its unit, spend the vast majority of their time outside of the acute care hospital on CCMC's campus. [Tr. at 36, 160, 169]. Indeed, they sometimes bring patients to hospitals other than CCMC. [*Id.* at 162-63]. Further, they report to one of eight stations to start each shift. [*Id.* at 29-30]. Only one of these stations is on CCMC's campus, and it is two and a half blocks away from the hospital itself. [*Id.* at 35]. The others are up to eight miles away, scattered throughout Delaware County, Pennsylvania. [*Id.*]. The paramedics and EMTs are assigned to these stations on a rotating basis. [*Id.* at 35].

Once they report for work, the paramedics and EMTs check their supplies and then prepare to respond to emergency calls. [*Id.* at 29]. These calls take them out of their station, and "on the road." Frequently, they meet patients in their homes or offices, or at the sight of traffic accidents. [*Id.* at 165]. This is where they perform their work – meeting patients and delivering care. [*Id.* at 36 (describing duties), 160 (same)]. Indeed, as Mr. Yates testified, paramedics and EMTs spend no more than 10% of their time in *any* ER during a typical shift. [*Id.* at 166].

Paramedics and EMTs escort patients into the CCMC ER in order to transfer care to ER staff. [*Id.* at 47-48, 160-61]. But, they do not remain there long. No witness testified that, under any circumstances, paramedics and EMTs remain in the ER for more than fifteen minutes at a time. [*Id.* at 131-32, 169]. Instead, the paramedics and EMTs anticipate getting a call every three and half minutes and thus quickly transition care of a patient and leave. [*Id.* at 169]. While they maintain an office within the CCMC ER, paramedics and EMTs use it only to file paperwork and restore their supplies, a task they also frequently do on the road. [*Id.* at 55, 60]. Indeed, that paramedics and EMTs do not perform their duties within the ER is not merely a matter of practice, nor a CCMC rule. Instead, it is a requirement of the Commonwealth, which, as noted above, specifically precludes paramedics from treating patients in hospitals. [*Id.* at 48-49, Employer Ex. 5].

No evidence in the record suggests that any of the eight EMS stations, including Station 100, meets the Board's definition of an "acute care hospital." 29 C.F.R. § 103.30(f)(2). In similar circumstances, the Board has applied the traditional community-of-interest test, not the Health Care Rule. [*See* ARD Dec. at 6 (noting that the traditional community-of-interest test applied in *Virtua Health, Inc.*, 344 NLRB 604 (2004), a case involving a petitioned-for

paramedics-only unit.)]. *See also Stormont-Vail, Healthcare, Inc.*, 340 NLRB 1205 (2003) (applying traditional community-of-interest factors to determine whether nurses in multi-site health care system that included acute care facility were appropriately included a single bargaining unit).

The Board's decision in *Visiting Nurses Association of Central Illinois*, 324 NLRB 55 (1997) is particularly instructive. There, the Board approved a decision separating a group of visiting nurses from other RNs working within the acute care hospital with which the visiting nurses' employer shared a facility. Strikingly, the regional director noted that two and a half blocks separated the visiting nurses' building from the hospital and that the "essential difference" between the work done by the visiting nurses and those in the hospital was "the travel involved." 324 NLRB at 57. The Board echoed this conclusion, noting that the visiting nurses' function was to perform home health and hospice care, services "distinct from those provided by" hospital staff. *Id.* at 55. It also took particular note of the two sets of nurses' "separate and distinct work functions, skills, and working conditions (work setting, dress, daily routine, and different hours)." *Id.* Thus, it approved the regional director's direction of election, which explicitly rejected the employer's argument that the Health Care Rule should control, *see id.* at 59, and instead analyzed the Board's traditional community-of-interest considerations. *Id.* at 60 (determining whether classifications employer sought to include in the unit shared supervision and regularly interacted with those named in the petition).

A similar factual scenario is presented here. Yet, the Acting Regional Director disregarded such precedent and applied the Health Care Rule. [ARD Dec. at 5]. Therefore, the Board should review the Decision in order to require appropriate community-of-interest analysis.

As explained below, under such analysis, a unit including both clinical assistants and paramedic/EMTs is not appropriate.

2. The Health Care Rule Does Not Apply in Self-Determination Elections Where There Are Existing Non-Conforming Units.

The Health Care Rule is clear: It does not apply "in circumstances in which there are existing non-conforming units." 29 C.F.R. § 103.30(a). The Board stated as much again in *St. Vincent Charity Med. Ctr.*, 357 NLRB No. 79 (2011): "[T]he Rule addresses only prospective, initial organizing of units in acute care facilities, and does not specifically address the situation which exists in the present case, i.e., where an acute care facility was partially organized in a nonconforming unit or combination of units. The Board specifically deferred such situations to adjudication." 357 NLRB No. 79, slip op. at 2 (citing 284 NLRB 1570-71). *See also Crittendon Hosp.*, 328 NLRB 879, (1999) ("By its own terms, the Rule applies *only* to initial organizing attempts or, where there are existing nonconforming units, *to a petition for a new unit of previously unrepresented employees*, which would be an addition to the existing units at the Employer's facility.") (emphasis added).

The Decision ignores this statement concerning the Rule's limits and instead relies upon *St. Vincent* exclusively for its conclusion that the presumptions required by the Rule apply here. [ARD Dec. at 4-5]. While *St. Vincent* states in dicta that the Board found "in connection with Health Care Rule making," that the nonprofessional employees at issue there shared a "presumptive" community of interest, 357 NLRB No. 79, slip op. at 2, it also analyzed whether those employees shared a community of interest under the traditional factors. *Id.* (finding the employees "perform the same functions, are in the same distinct employee classifications, are organizationally included in the same administrative division in the hospital laboratory, work in the same location in the Employer's hospital, and have the same

supervision"). Indeed, to apply the presumptions required by the Rule while simultaneously concluding that the Rule itself does not apply is contradictory. To the extent *St. Vincent* does so, as the Decision here suggests, it is wrong.

A more accurate reading of the Rule and Broad precedent concerning its limits makes clear that, here, the Rule is inapplicable. It is undisputed that there are several nonconforming units at CCMC. Petitioner represents paramedics and EMTs, both of which are technical employees. [ARD Dec. at 1]. Another union represents "all technical employees." [*Id.* at 2; Joint Ex. 2]. A third represents both technical and non-technical employees in several specific classifications, including LPNs and patient care technicians. [ARD Dec. at 2; Joint Ex. 3]. It is also beyond dispute that Petitioner seeks a self-determination election among the PRN paramedic/EMTs and the clinical assistants. [Tr. at 11, 193]. Application of the Health Care Rule – to the extent it is interpreted to require disregard for traditional community-of-interest analysis here – therefore, is entirely inappropriate. By the Rule's very terms, it is irrelevant to the issue of whether or not clinical assistants should be grafted onto the Petitioner's current unit of paramedics and EMTs.

Thus, the Board must review the Decision because it ignores both the clear language of the Rule and Board precedent, including the very case on which it relies, and require the Acting Regional Director apply traditional community-of-interest analysis.

3. No Presumption in Favor of a Finding That Clinical Assistants and Paramedic/EMTs Share a Community of Interest Is Applicable.

For the reasons explained above, the Rule, and the presumption it would impose in favor a finding that the clinical assistants and paramedic/EMTs share a community of interests, do not apply to this case. Therefore, the Acting Regional Director departed from precedent by requiring CCMC to bear a "heavy burden" in order to establish that clinical

assistants should not be grouped with paramedic/EMTs for the purposes of bargaining. [ARD Dec. at 5]. The Board has made abundantly clear that, in non-acute care settings, traditional community-of-interest factors apply. *See Specialty Healthcare & Rehab Ctr. of Mobile*, 357 NLRB No. 83, slip op. at 12. Therefore, the Acting Regional Director was required to perform careful analysis of all the Board- mandated community-of-interest factors, without regard to any supposed presumption in favor of inclusion. *Id.* at 14 (quoting *United Operations, Inc.*, 338 NLRB 123, 123 (2002)). He failed to do so. [ARD. Dec. 7].

Instead, he gave mere lip-service to this analysis, relying on *Virtua Health, Inc.*, 344 NLRB 604 (2005) to suggest that clinical assistants "might" share a community of interest with paramedic/EMTs. [*Id.* at 6-7 n.1]. This conclusion, to the extent it can be considered a conclusion at all, is itself an error of both law and fact because *Virtua Health, Inc.* did not concern employees like the clinical assistants here. Instead, it dealt with a group of non-paramedic technical employees who performed functions similar to the paramedics at issue, including "starting IVs, drawing blood, administering CPR, EKGs, and medication, and using telemetry." 344 NLRB at 605. The paramedics, in contrast to those at CCMC, worked in the employer's emergency room on occasion, working alongside ER personnel. *Id.* Both the paramedics and other technical employees were subject to the same employer policies and had the same wage and benefits. *Id.* As demonstrated above, the situation at issue here is much different. Therefore, the Decision's conclusion that traditional community-of-interest analysis is inapplicable here and the constricted analysis it purported to perform are both in error.

Thus, the Board must review the Decision in order to require the Acting Regional Director to apply traditional community-of-interest analysis. As explained below, such analysis

reveals that the Petition's proposed grouping of employees is inappropriate under Board precedent.

4. Extraordinary Circumstances Exist Sufficient to Deviate from the Rule.

Even in those situations in which the Rule would otherwise apply, the Board allows deviation from it when justified by "extraordinary circumstances." Such circumstances arise when a party can demonstrate that "its arguments are substantially different from those which have been carefully considered at the rulemaking proceeding, as for instance, by showing the existence of such unusually and unforeseen deviations from the range of circumstances revealed at the hearing and known to the Board from more than 13 years of adjudicating cases in this field." 53 Fed. Reg. at 33,933 (quotation omitted). Here, the Decision fails to consider meaningfully whether the record supports a finding that such circumstances exist. [ARD Dec. at 7]. However, a close reading of the facts in evidence demonstrates that review should be granted to explore this very issue.

In establishing the Rule, the Board stated that it found technical employees would appropriately be joined together for purposes of bargaining in most cases based primarily on the "separate and distinct" nature of their duties, as opposed to that of other employees in acute care facilities, with a particular focus on the level of care they delivered. 53 Fed. Reg. at 33,918. It also considered the fact that, typically, "the evidence shows that the wages and hours of technical employees differ significantly from those of the other non-professionals." *Id.* at 33,919. Other factors considered by the Board include that "[t]echnical employees typically perform their work in laboratories or in technical departments, and not in patient care areas." *Id.*

The record here demonstrates that, at CCMC, none of these considerations apply. Rather, clinical assistants have duties similar to some non-technical employees. [Tr. at 75-76, 83]. *See also Rush Univ. Med. Ctr.*, Decision and Direction of Election, Case 13-RC-132042,

slip op. at 4 (Jul. 31, 2014) (finding patient care technicians to be non-professional employees under the Rule), *request for review denied* Case 13-RC-132042 (Aug. 27, 2014). In fact, as explained above, clinical assistants share very little in common with the CCMC paramedics and EMTs, whose primary duties involve traveling to the site of accidents or emergencies, performing life-saving care (advanced life support, in the case of paramedics), and safely transporting patients to the ER. [Tr. at 36, 160; Employer Exs. 2, 4]. Further, the record demonstrates that the wages and benefits of clinical assistants and paramedic/EMTs share next to nothing in common. [Tr. at 96-97, 99, 103-05; 110-11; Joint Ex. 1 at 18-24; Joint Ex. 1-A at 2-5; Employer Ex. 8]. Instead, clinical assistants share such terms and conditions of employment with other non-unionized CCMC staff, regardless of their classification under the Rule. [Tr. at 96, 99, 103-04]. With regard to work areas, neither clinical assistants nor paramedic/EMTs work in laboratories as contemplated by the Rule. Rather, clinical assistants work in the ER. [Tr. at 72-73, 83]. Paramedics and EMTs work in their assigned stations and on the road. [*Id.* at 29-30, 36, 160].

Therefore, the Board should review the Decision to determine whether the record supports a finding of extraordinary circumstances sufficient to justify an exception to the Rule. Doing so, it will discover that the circumstances presented here differ in nearly every way from those considered by the Board when it established the Rule. In other words, here, should the Rule apply, the circumstances presented justify deviation from it and the Petition should be reviewed under the Board's traditional community-of-interest analysis.

B. <u>The Acting Regional Director Reached Erroneous Factual Conclusions.</u>

Guided by its misapplication of the Health Care Rule, the Decision gives the record short shrift. Specifically, it fails to portray the differences between clinical assistants and paramedic/EMTs accurately. Therefore, the Board should review the Decision to consider the

facts in evidence more carefully. Such consideration will demonstrate both that the two sets of employees do not share a community of interest and that they are not a distinct, identifiable group appropriate for collective bargaining.

1. The Record Demonstrates That Paramedic/EMTs and Clinical Assistants Do Not Share a Community of Interests.

Ignoring the vast evidence to the contrary, the Decision concludes summarily "[t]he two groups have regular contact when paramedics bring patients to the Emergency Room for treatment," "[t]heir basic functions are similar," and that the two groups are "functionally integrated." [ARD Dec. at 6]. None of these conclusions is correct. Instead, testimony demonstrated that contact between the two groups is not "regular." Rather, EMTs and paramedics regularly transport patients to the CCMC ER, where they are met by a nurse. [Tr. at 47-48]. On the relatively rare occasion that they deliver a patient to the front of CCMC's ER, they may be met by a clinical assistant [*Id.* at 161-62], but no witness testified that such interaction is regular.

Nor does evidence suggest that the two groups have similar, integrated functions. EMTs and paramedics provide direct medical care, including advanced life support (for paramedics), dispensing medication, drawing blood, and inserting IVs. [*Id.* at 163-64, 166]. They also provide transport from the scene of a call to the hospital doors. [*Id.* at 36, 160]. Though clinical assistants have paramedic training, what they do is very different; it involves initially assessing patients as they enter the ER, providing basic care, and escorting certain patients throughout the hospital. [*Id.* at 74-78]. The Acting Regional Director cited one piece of evidence to find that the two groups of employees performed the same function – testimony by a clinical assistant regarding work she did as a paramedic for a different employer six years ago. [ARD Dec. at 6; Tr. at 116]. This conclusion ignores the lengthy descriptions other witnesses

provided regarding the duties associated with each classification, as well as the testimony from the very witness relied upon by the Acting Regional Direction making clear that many of the skills possessed by paramedics, all of which relate to their duties, is "not anything that's in the hospital. That would be something for the paramedics on the road." [Tr. at 134].

A more accurate review of the record reveals that the paramedic/EMTs and clinical assistants share very little of the traditional community-of-interest factors in common. As the Board has made clear, those factors are as follows:

- Whether the employees are organized into separate departments;
- Whether the employees have distinct skills and training;
- Whether the employees have distinct job functions and perform distinct work;
- Whether the employees are functionally integrated;
- Whether they have frequent contact with one another;
- Whether they are interchangeable;
- Whether they have distinct terms and conditions of employment; and
- Whether they are separately supervised.

Specialty Healthcare & Rehab Ctr. of Mobile, 357 NLRB No. 83, slip op. at 14. *See also NLRB v. Action Automotive, Inc.*, 469 U.S. 490, 491 (1985) (describing factors to be considered when determining whether community of interest exists, and thus whether a petitioned-for unit is appropriate); *Bartlett Collins Co.*, 334 NLRB 484, 484 (2001) ("In determining whether the employees possess a separate community of interest, the Board examines such factors as mutuality of interest in wages, hours, and other working conditions; commonality of supervision; degree of skill and common functions; frequency of contact and interchange with other employees; and functional integration."); *Bank of America*, 196 NLRB 591, 593 (1972)

(employees at separate location, having little day-to-day interaction with those in petitioned-for group, have a distinguishable community of interest).

Here, the following is not disputed by any credible evidence in the record:

- Paramedic/EMTs are in the EMS Department, but clinical assistants are in Emergency Department [Tr. at 26-28, 70, 87; Employer Ex. 1; Joint Ex. 7];
- Paramedics and EMTs have skills and training clinical assistants do not [Tr. at 74-78, 134; Employer Exs. 2, 4, 6];
- There is no overlap between the work of the clinical assistants and the paramedic/EMTs, in part because paramedics may not provide care in the ER as a matter of Pennsylvania law [Tr. at 75; Employer Ex. 5];
- Paramedic/EMTs spend the vast majority of their time outside the hospital, responding to emergency calls and transporting patients [Tr. at 165-66-69];
- Paramedic/EMTs interact with doctors, nurses, and, on limited occasions, clinical assistants [*Id.* at 161-62, 170];
- Clinical assistants cannot serve as paramedic/EMTs and paramedic/EMTs fill shifts as clinical assistants only rarely [*Id.* at 62];
- The wages, benefits, uniforms, and other terms of employment for clinical assistants and EMTs are nearly all distinct [*Id.* at 85, 91-92, 96, 99, 100, 103-04, 110-11; Joint Ex. 1; Joint Ex. 1-A; Employer Ex. 8]; and
- The two groups of employees do not share any supervisors in common [Tr. at 46, 50, 70, 140].[7]

Contrary to the Acting Regional Director's assessment of the facts, therefore, no factors suggest that the paramedic/EMTs and clinical assistants share a community of interest. [ARD Dec. at 6].

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[7] The Decision seems to suggest that, because clinical assistants take direction from the same ER doctors who provide guidance on medical procedures to paramedic/EMTs, the two groups share supervision. [ARD Dec. at 3]. No evidence supports this conclusion. Chief Reeder and his assistant chiefs supervise paramedic/EMTs. [Tr. at 45-46]. ER doctors advise paramedic/EMTs on medical issues that arise when they are in the field. [*Id.* at 164]. No evidence suggests those doctors have the authority to hire, transfer, suspend, lay off, recall, promote, discharge, assign, reward, or discipline them; are responsible to direct them; adjust their grievances; or effectively recommend any such action. *See* 29 U.S.C. § 152(11) (defining "supervisor").

Undoubtedly, this flawed reading of the record has prejudiced CCMC, which now faces the possibility of bargaining with one union over the terms and conditions of two distinct groups of employees – the very situation the Board's prescribed community-of-interest test is intended to prevent. *Action Automotive, Inc.*, 469 U.S. at 494 (noting need to create "cohesive" bargaining units, free internal of conflict, and in which minority interests are not submerged).

Therefore, CCMC respectfully requests that the Board grant review of the Decision in order to require a full and fair review of the record and the myriad facts demonstrating that clinical assistants and paramedic/EMTs do not share a community of interest.

2. The Record Demonstrates That Together, Paramedic/EMTs and Clinical Assistants Are Not A Distinct, Identifiable Group.

Correctly, the Decision notes that "a determination as to whether a particular combination of employees is an identifiable group is not 'another version of community interest analysis.'" [ARD Dec. at 8 (quoting *DPI Security, Inc.*, 362 NLRB No. 172, slip op. at 4 n.10 (2015))]. However, it then errs in determining that the two groups of employee here, when combined, are such a group. The Board should review this conclusion of fact in order to require a more accurate reading of the record.

The Board has held that employees may be combined into a single unit when they are "readily identifiable as a group (based on job classification, departments, functions, work locations, skills, or similar factors)." *Specialty Healtcare*, 357 NLRB No. 83, slip op. at 12. *See also Bergdorf Goodman*, 361 NLRB No. 11, slip op. at 2 (2014). But here, the facts make clear that the clinical assistants and paramedic/EMTs share none of these in common. Indeed, the Acting Regional Director almost concedes as much, focusing only the fact that they "appear to constitute all of the unrepresented employees in the Employer's workforce with paramedic training and certification." [ARD Dec. at 8]. This conclusion ignores the weight of the record,

including the undisputed facts that the employees work in separate locations and report to different supervisors. [Tr. at 29-30, 46, 50, 70, 72-72, 140, 165-66]. It also ignores the fact that the two groups of employees are not "readily identifiable" because they wear distinct uniforms and operate in entirely different locations. [*Id.* at 85, 91-92].

Even if the Board's test called for analysis only of the two groups' skills, training, and functions, the Decision would be flawed. Paramedic/EMTs must have training and skills that clinical assistants do not so that they can perform the most essential duties associated with their positions – providing pre-hospital advanced and basic life support and transportation. [*Id.* at 36, 41-43, 134, 160; Employer Exs. 2, 3, 4]. While clinical assistants must be EMS certified, they do not function as paramedics. [Tr. at 74-75]. Indeed, they may not function as paramedics under state law. [*Id.* at 74-75, 77-78; Employer Ex. 5]. The Decision does not even mention this fact.

It also fails to capture the function of the paramedic/EMTs, which the Acting Regional Director defines as "assessing patients and performing preliminary tests necessary to determine appropriate treatment." [ARD Dec. at 8]. Though a correct summation of a part of clinical assistants' duties (but neglecting their responsibility to escort non-critical care patients to other areas of the hospital [Tr. at 72-73, 83]), this description is flatly incorrect as it relates to the paramedic/EMTs. Employees in those classifications respond to emergency calls and provide direct life-saving support, including, for paramedics, advanced life support. [*Id.* at 36, 160]. They draw blood and administer medicine. [*Id.* at 163-64, 166]. They also make critical decisions regarding the appropriate destination for each patient and, when necessary, consult with medical personnel. [*Id.* at 47-48, 64, 67, 160, 169]. Thus, the Acting Regional Director's attempt to "broadly" define the function of the paramedic/EMTs is simply incorrect.

Therefore, CCMC respectfully requests that the Board grant review of the Decision in order to require a full and fair review of the record and the myriad facts demonstrating that clinical assistants and paramedic/EMTs are not a distinct identifiable group.

C. The Process by which the Decision Was Announced Suggested that the Merits of the Petition Were Prejudged.

The Board may grant review of a decision when "the conduct of any hearing or any ruling made in connection with the proceeding has resulted in prejudicial error." 29 C.F.R. § 102.67(d)(3). Here, just such a circumstance has occurred.

One day before the Decision issued, the parties were informed that an entry on the NLRB's online docket sheet for the case indicated that an election had been ordered. The Regional Office explained to the parties that "[w]hat we believe happened is that the Elections Clerk prepared a Notice of Election prospectively based on some information in the file so she would have something to work from when the Decision would be finalized. That information was somehow posted. We are contacting our IT department to track down the glitch which caused the information to be posted." [*See* E-mail from K. O'Neill (Dec. 3, 2015), attached as Exhibit A]. The parties were directed to disregard the order and instructed that the issues raised by the Petition were still under review. [*Id.*]. Notably, the mistakenly posted information precisely tracked the results found in in the Decision, and that which the Petitioner sought. [*See Crozer-Chester Medical Ctr.*, Case No. 04-CA-164030, Docket Sheet (Dec. 3, 2015), attached as Exhibit B].

That the Regional Office had an electronic docket entry prepared in advance of a decision having been made suggests that no full and fair consideration was ever given to the facts and arguments the parties presented. Rather, it appears that the Regional Office decided that it would issue an order matching Petitioner's requested unit and merely needed to determine how

to justify that decision before announcing it formally. Indeed, the Decision's selective and, in some cases, patently incorrect review of the facts lends credence to such a suspicion.

CCMC was assuredly prejudiced by the irregularity of the proceedings. It presented extensive evidence at the hearing held regarding the Petition, only to be ignored. It also awaited a decision before engaging in any sort of communication with employees in the sought-after classifications. Meanwhile, it appears that the Regional Office knew all along what it would decide.

Therefore, CCMC respectfully requests that the Board grant review of the Decision in order to require a full and fair review of the record and the parties' respective positions. Only by doing so can it make certain that a decision in this case represents appropriate consideration of the issues at hand and was not the result of prejudgment.

V. CONCLUSION

In reaching a Decision in this case, the Acting Regional Director erred in departing from Board precedent and in his factual conclusions. In addition, the process by which the Decision was announced suggests that the issues presented by the Petition were prejudged. All of these errors prejudiced CCMC, which now faces the prospect of bargaining with an impermissibly grouped collection of employees who perform distinct functions, report to different supervisors, and work within different departments, among their other differences noted above. Such a circumstance has the potential to thwart the Act's purpose of promoting industrial peace by creating an inappropriate unit of employees that will undoubtedly complicating and prolonging negotiations and other collective bargaining activities. Therefore, the Board should exercise its discretion to review the Acting Regional Director's Decision and require a result consistent with its precedent and with the facts in the record.

Respectfully submitted,

Date: December 30, 2015

Daniel V. Johns
Christopher T. Cognato
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1735 Market Street, 51st Floor
Philadelphia, PA 19103

Attorneys for Crozer-Chester Medical Center

CERTIFICATE OF SERVICE

A copy of the Request for Review of the Acting Regional Director's Decision and Direction of Election of the Employer, Crozer-Chester Medical Center, has been served on Counsel for Petitioner and the Regional Director of Region 4 via electronic mail and regular mail.

Christopher T. Cognato

December 30, 2015
Date

EXHIBIT A

From: "O'Neill, Kathleen" <Kathleen.oneill@nlrb.gov>
Date: December 3, 2015 at 3:47:06 PM EST
To: "Johns, Daniel" <Johns@ballardspahr.com>, Jonathan Walters <JWalters@markowitzandrichman.com>
Subject: Crozer Chester Hospital 04-RC-164030

Dan and Jon,
I was advised by John Walters that the NLRB website lists election arrangements for the subject case, including a unit description, but no Decision and Direction of Election is posted. I just spoke with the Regional Direction. He asked me to advise you that the Decision and Direction of Election has not issued. In fact, it is still in the review process. What we believe happened is that the Elections Clerk prepared a Notice of Election prospectively based on some information in the file so she would have something to work from when the Decision would be finalized. That information was somehow posted. We are contacting our IT department to track down the glitch which caused the information to be posted. Please do not rely on the information posted on the NLRB website regarding election arrangements at this time. Instead, you should rely on the election information contained in the Decision when it issues. We apologize for the error.

Kathleen O'Neill
National Labor Relations Board
615 Chestnut Street
7th Floor
Philadelphia, PA 19106

215-597-7645 (ph)
215-597-7658 (fax)

EXHIBIT B

Crozer Chester Medical Center

Case Number: 04-RC-164030
Date Filed: 11/12/2015
Status: Open

Location: Upland, PA
Region Assigned: Region 04, Philadelphia, Pennsylvania

Docket Activity

Date	Document	Issued/Filed By
12/03/2015	Notice of Election*	NLRB - GC
11/17/2015	Initial Letter to Intervenor in an R case*	NLRB - GC
11/17/2015	Initial Letter to Intervenor in an R case*	NLRB - GC
11/12/2015	Signed RC Petition*	Petitioner

The Docket Activity list does not reflect all actions in this case.

* This document may require redactions before it can be viewed. To obtain a copy, please file a request through our FOIA Branch.

Elections

Ballots Mail Date: 12/10/2015
Eligibility Date: 11/29/2015
Time: 5:00 p.m.

Ballots Count Date: 01/04/2016
Place: from the Regional Office

In order to be valid and counted, the returned ballots must be received by the NLRB prior to the counting of the ballots.

Eligible Voters:
All employees who were employed in the bargaining unit below during the payroll period ending 11/29/2015 and on the day the voter mails the ballot to the NLRB.

Election Status: Open

Voting Unit:
INCLUDED: All PRN paramedics and emergency medical technicians and all full-time, regular part-time and PRN clinical assistants employed by the Employer EXCLUDED: All other employees, guards, and supervisors as defined in the Act.

Participants

Participant	Address	Phone